May 4, 2000

Timothy Westmoreland
Director
Division of Integrated Health Services
Center for Medicaid and State Operations
Health Care Financing Administration
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: 11-W-00051/1

Dear Mr. Westmoreland:

The following represents responses to the programmatic questions raised to date regarding Vermont's request for the extension of its 1115 demonstration project. Answers are italicized.

General Questions regarding *PC Plus* (Vermont's primary care case management program):

Please describe how the State has monitored the performance of PCPs under *PC Plus*.

PC Plus has been operational since October 1, 1999, just over six months. During this time, the State has monitored PCP performance mainly through member feedback via the Health Access Member Services Unit at Maximus. Feedback obtained by the MSU is forwarded to OVHA through weekly reports from Maximus.

OVHA is in the process of obtaining a contractor to administer a member satisfaction survey (CAHPS) to gain additional input on PCP performance and general member satisfaction with the PC Plus program. The survey will be carried out over the summer, with results due in September.

Some States have experienced difficulty managing the utilization of the ER under PCCM models. Please describe how Vermont has addressed/will address this issue.

OVHA is addressing the ER issue on two fronts:

(1) The state's Department of Banking, Insurance, Securities and Health Care

Administration (BISHCA) sponsors a provider/plan workgroup consisting of providers and managed care plan representatives. Since problems associated with ER usage are common to commercial insurers as well as Medicaid/PC Plus, this group has established a subgroup that is working on issues related to inappropriate ER use and methods of ensuring that notes from ER visits are provided to beneficiaries' PCPs. OVHA has representation on both of these committees.

(2) OVHA plans to bring together a PCP workgroup to offer input on how we can enhance PC Plus for providers. One of the issues we will be discussing is what kind of quality improvement projects we can implement to manage ER usage.

Please describe how grievances and appeals under *PC Plus* have been tracked and monitored.

Most requests for fair hearings related to service issues come through the Health Access Member Services Unit. OVHA has established a process whereby requests are routed to a designated staff person at OVHA who checks to see if the requestor is a PC Plus member. If he/she is, the designated staff person logs the request and tracks the progress of the fair hearing. Our PC Plus regulations require us to keep an appeals register and produce periodic appeals reports.

Please describe how the State has ensured twenty-four hour, seven-day access under *PC Plus*.

The PC Plus participation agreement lists as one of the requirements that PCPs provide 24 hour, 7-day coverage. If a PCP office cannot provide that coverage, we will not enroll them in the program. It should be noted that Vermont is a small state. Most of the PCPs who participate in PC Plus also participate in other managed care plans that also require this coverage.

Members are advised to call Health Access Member Services if they have problems getting appointments. If a member calls indicating that his/her provider is not meeting the coverage standard, the issue would be referred to Provider Relations at EDS and staff there would contact the PCP's office. If the PCP cannot provide the required coverage, he/she would not be allowed to participate in the program.

Issues for People Living with HIV/AIDS (PLWHA):

How has the State addressed the increased cost of care for PLWHA in its capitated rates for those that remain in a capitated MCO since treatment with highly active antiretroviral therapies (HAART) includes more potent, expensive prescription drugs than existed when the waiver was initially approved in 1995?

This is not an issue as the pharmacy benefit for individuals enrolled in the capitated health plans was carved out effective 2/1/99. Pharmaceuticals are currently being managed on a fee-for-service basis by Medicaid.

Under Vermont's goals (page 3), its lists one of "allowing disabled persons, and other individuals with serious, chronic health conditions to select a physician specializing in their area of disability/illness to serves as a PCP"? Does that include PLWHA?

Yes.

Vermont receives Ryan White CARE Act benefits: Title II funds, which includes the AIDS Drug Assistance Program, and funding for one Title III site, Fletcher Allen Health Care in Burlington. Please describe any involvement of the staff who administer the Ryan White CARE Act program and/or PLWHA in the demonstration extension proposal.

OVHA has worked with the Drug Assistance Program staff at the Vermont Department of Health to improve the coordination of the VHAP drug benefit. For VHAP beneficiaries with HIV/AIDS, the Drug Assistance Program provides assistance for coinsurance obligations when necessary. In addition, OVHA staff participates in the statewide Primary Care Steering Committee, which includes in its focus issues related to the care needs of PLWHA. PC Plus staff is also setting up meetings with the staff of the Fletcher Allen site to improve communication and service coordination for PC Plus beneficiaries.

Have you created any other special program features for the new *PC Plus* model for children with disabilities (e.g., family programs, expanded use of special CPT codes, quality performance monitoring)?

PC Plus staff are working closely with the Vermont Department of Health's Children with Special Health Needs program in supporting various groups in the state, specifically Parent-to-Parent, in their efforts to promote the American Academy of Pediatrics' Medical Home Program for children with complex or disabling clinical conditions.

OVHA is also involved in an ongoing case management project where staff has surveyed state agencies and providers who perform care coordination services. One of the project's goals has been to identify children with special health needs/chronic conditions who do not receive care coordination from other programs, such as CSHN, Family Infant and Toddler Project, Healthy Babies/One to Five. OVHA's long range plan is to develop the capacity in PC Plus to offer these services.

PC Plus staff, the Department of Health, and the State's social service agency are collaborating on a project to help ensure that children in custody receive regular well-child care as studies have shown that children whose placements are constantly changing often do not get the preventive care they need.

Have you developed any specific mechanisms to encourage coordination of mental health services for children with serious emotional disturbances and other less complex mental health conditions? (The extension request only mentions coordination efforts for adults who are seriously mentally ill).

Adults with serious and persistent mental illnesses are specifically included in the waiver population if they are enrolled in the Department of Developmental and Mental Health Services' Community Rehabilitation and Treatment Program. Many children with severe emotional disturbance are on the SED waiver and are therefore not included in the 1115 population. Regardless of their waiver status, however, OVHA is concerned with the coordination of primary and behavioral health services for children, especially as it relates to the appropriate prescription of psychoactive medication. OVHA's Drug Utilization Review Board is currently conducting a focused review of primary care prescribing practices in this area, which will be submitted to the PC Plus Quality Improvement Committee upon completion.

Regarding Vermont's quality monitoring priority areas for children, it would be beneficial to look not only at diagnosis but also at treatment of affective disorders in ambulatory settings. In addition to adults with serious and persistent mental illness, it would be useful to pursue quality assurance activities for children with serious emotional disturbances and other mental health or substance abuse conditions. Please describe any existing monitoring of this type, or any future plans in this area.

Vermont is partnering with the Vermont Department of Health and the University of Vermont Department of Pediatrics in a statewide Preventive Services Initiative. Currently, 22 practices have agreed to participate in the project, which will establish a program to measure the delivery of preventive services, establish feedback mechanisms for practitioners, develop practice-specific strategies for improvement, and identify opportunities for collaboration among practices to sustain improvement efforts. Behavioral health services (including substance abuse) are a focus area for this initiative.

Comment: Since the *PC Plus* model will include many children with mental retardation and other children with complex physical conditions, it may be useful to consider one or more quality monitoring activities for this population (e.g., focused studies on annual comprehensive evaluations or compliance with plans of care).

Noted. We hope to identify such projects primarily through our collaboration with parent and family groups, such as Parent-to-Parent; providers; and state agencies, such as the Department of Health's Children with Special Health Needs Program.

Technical Edits/Clarifications:

The suggested changes listed here have been made to the text of the renewal document. We are proposing, though, that we submit the corrected pages after all correspondence regarding the waiver extension is addressed. In that manner we all may be assured that they are the finalized versions.

Page 2, 1st paragraph: Add a sentence: "The initial 1115 is effective January 1, 1996 for five years."

Noted.

Page 7, at the end of the page: Something should be noted that after Dec. 2, 1999 the State and VT BC/BS were unable to come to agreement over capitation rates for a continued risk HMO contract and, thus, Blue First is being phased out of the 1115 by no later than June 30, 1999.

Noted.

Page 8: Label the exhibit as of June, 1999.

Noted.

Page 16, last paragraph: Note that the 150% to 175% is for maintenance drugs only.

Noted.

Note in General: The references in this extension request to the protocol are references to the old protocol.

Acknowledged.

Page 17, Item 3: The RO is in the process of reviewing the new protocol.

Noted.

Page 19, 3rd line: The protocol reference should be to Part 2, Section 12, Item III.

Noted.

Page 19, line before "Provider Capacity": The protocol reference should be to Part 2, Section 6, Item VII.

Noted.

Page 21, Item D: The protocol reference should be to Part 2, Section 11.

Noted.

Pages 21 & 22, Item F: We believe the State should say something here that not all encounter data came easy.

Noted.

Page 25, 2nd line: Reference is made to "The Quality Monitoring Plan". Please ask the State to elaborate on what this is.

The Quality Assurance Monitoring Plan, which describes the procedures and process used by the State to oversee the MCO's compliance with Federal and State statutes regarding quality of care and consumer protection, is included in Part 2, Section 7 of the Operational Protocol. The State also conducts financial reviews of both plans. Copies of the State's findings from these reviews are available to HCFA upon request. ***The Quality Assurance Monitoring Plan, which describes the procedures and process used by the State to oversee the MCO's compliance with Federal and State statutes regarding quality of care and consumer protection, is included in Part 2, Section 7 of the Operational Protocol. The State also conducts financial reviews of both plans. Copies of the State's findings from these reviews are available to HCFA upon request.***

Page 25, 3rd line: The reference to the protocol should be Part 2, Section 7.

Noted.

Page 25: Discussion describing the Standing Committee to the DDMHS Commissioner should be added for CRT.

The Office has established a Quality Improvement Advisory Committee to assist the State in moving towards a comprehensive and integrated quality improvement system. The QI Advisory Committee was established to assist the Office in developing

a comprehensive quality improvement program for the Vermont Health Access Plan. The committee includes consumers, advocates, health plan representatives, provider representatives, and State staff. In addition, staff and consumer representatives from the Community Rehabilitation and Treatment Program of DDMHS participate in the program, through the CRT Standing Committee to the DDMHS Commissioner, and through their involvement with the Quality Improvement Advisory Committee. The Quality Improvement Advisory Committee (QIAC) is chaired by the Managed Care Director.

Page 30, 2nd line: The reference to the protocol should be Part 4.

Noted.

Page 30, last bullet: The new draft protocols the RO is currently reviewing meet this requirement.

Noted.

Page 31: Add a discussion about the CRT consumer satisfaction surveys done by DDMHS.

The State has monitored beneficiary satisfaction levels since the start of the VHAP program. Annual beneficiary satisfaction surveys collect data on geographic locations of providers, appointment scheduling, office waiting times and availability of provider types. In addition, DDMHS conducts biannual surveys of consumer satisfaction with the Community Rehabilitation and Treatment services received through the Department's Designated Agencies.

Page 38: The State makes reference to "projected CRT expenditures". Since the CRT program for the 1115 has been operational since April 1, 1999 there should be some actual data to use in this extension request.

Information to be included in the financial section of the responses to questions.

We trust that these answers address the issues raised to date. If you have questions regarding these or other programmatic questions, feel free to contact M. Elizabeth Reardon at 802-241-2743 (*lizr@wpgate1.ahs.state.vt.us*) or Ann Rugg at 802-241-2766 (*annr@wpgate1.ahs.state.vt.us*). Our response to your financial questions will follow under separate cover.

Sincerely,

Eileen Elliot
Commissioner

cc: Paul Wallace-Brodeur
M. Elizabeth Reardon
Ann Rugg